



Division of Child Care & Early Childhood Education
P.O. Box 1437, Slot S140, Little Rock, AR 72203-1437
P: 501.682.8590 F: 501.683.6060 TDD: 501.682.1550

Notice of Serious Incident

Date of Incident: 3/16/2023

Date Received by DCCECE: 3/16/2023

Facility Name: Dacus RTC

Facility Number: 108

Facility Type: Residential

Incident Type: Licensing

Report Description: Client: [REDACTED] Birth date: [REDACTED] Summit Community Care Private pay Guardian: mother-[REDACTED] Staff present: [REDACTED], [REDACTED] Date of Incident: 3/16/2023 Client [REDACTED] was transitioning to the gym. Client [REDACTED] did not use stair protocol and ran down the stairs. Client [REDACTED] fell down the last three steps and landed on the right side of his face, causing approx. [REDACTED]. Client [REDACTED] was taken to the NEA Baptist ER. Client [REDACTED] had [REDACTED]. [REDACTED] The skin was glued. The x-ray revealed no fractures, no air-fluid levels, and the paranasal was clear. Client ([REDACTED]) was prescribed [REDACTED] for pain as needed. Client ([REDACTED]) was reminded of the importance of following stair protocol and the dangers of not following stair protocol upon return to the facility.

Interim Action Narrative: Resident was transported to NEA Baptist ER for further evaluation. Skin was glued. Resident was reminded of stair protocol upon return to the facility.

Maltreatment Narrative:

Licensing Narrative: Licensing Specialist will inquire about camera footage. 3/21/2023,
Licensing Specialist reviewed camera footage. No licensing concerns observed.



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521 Visit Compliance Report

Licensee: Dacus RTC

Facility Number: 108

Licensee Address: 211 CHURCH STREET
BONO AR 72146

Licensing Specialist: Kendra Rice

Person In Charge: Waynette Banks

Record Visit Date: 3/21/2023

Home Visit Date: 3/21/2023

Purpose of Visit: Self Report Visit

Regulations Out of Compliance:

Regulations Needing Technical Assistance:

Regulation Not Applicable:

Regulations Not Correctable:

Narrative:

Time of Visit: 3:30 pm to 4:00 pm

Census: 11

Licensing Specialist reviewed camera footage for a provider reported incident on 3/16/2023.

Licensing Specialist observed residents and staff members going down the stairs, ratio 2:7. Staff members were positioned at the top and bottom of the stairs. Licensing Specialist observed the resident leaning on the rail on the wall leading down the stairs. Resident was observed sliding down the rail of the stairs and what appeared to have jumped on a stair.

Licensing Specialist was unable to observe the resident jumping but observed the resident laying on the floor at the end of the stairs. Residents turned around to the resident falling and staff members were observed assisting the resident.

Ms. Tiffany (Care Manager) informed Licensing Specialist that resident does not have a scheduled follow-up appointment. Facility was encouraged that if resident have complaints of pain for him to return.

Provider Comments:

CCL Staff Signature :

Date: 3/21/2023



Provider Signature :

Date: 3/21/2023

